NEIL ABERCROMBIE
GOVERNOR

STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
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www.eutf.hawaii.gov

January 4, 2011

TO: Active Hawaii State Teachers Association Members (Bargaining Units 05/45)

FROM: for Marie C. Laderta, Acting Administrator Sandi Jahn

SUBJECT: Open Enrollment Information – Addendum to Memo Dated December 27, 2010

Below are additional questions and answers to assist you during the EUTF's open enrollment period which started January 3, 2011 and ends January 24, 2011. {Note: The first 30 questions and answers were provided in a memo dated December 27, 2010, which is posted on the EUTF's website at: www.eutf.hawaii.gov.}

Q31: In Q&A #11 which was issued earlier, you said that if I do not want to switch to the EUTF plans available to all other State and County employees, but want to add or drop a dependent under the plans EUTF created for HSTA VEBA members, I could do so. Do I need to complete the EC-1 form to do that?

A31: No. You will need to complete the new EC-1H form which is attached, and which can also be downloaded from the EUTF website at: www.eutf.hawaii.gov. You only need to complete Sections 1, 4, and 6. Under Section 1, be sure to check the block for Open Enrollment. Under Section 4, be sure to indicate whether you wish to add or delete a dependent.

Q32: The EC-1 form and the new EC-1H form look very similar. When should the EC-1 form be used and when should the new EC-1H form be used?

A32: The 2 forms may look similar but are NOT identical. Therefore, during the open enrollment period:

- Use the EC-1 form if you want to **switch** from the VEBA-type plan you were automatically enrolled in, effective January 1, 2011, to the EUTF plans available to all other State and County employees, effective March 1, 2011.
- Use the new EC-1H form if you want to **stay in** the plans EUTF created for HSTA VEBA members and **the only change you wish to make is to add or drop a dependent**.

City Financial Tower 201 Merchant Street Suite 1520 Honolulu Hawaii 96813

Q33: I know that on January 1, 2011, HSTA VEBA members were automatically transitioned to the VEBA-type plans which EUTF created for us, in compliance with Judge Sakamoto's oral ruling. However, do we all have to submit EC-1 forms during the open enrollment period to maintain our coverage from March 1, 2011?

A33: No. If you were automatically transitioned to a VEBA-type plan on January 1, 2011, and you do not wish to make any changes to your coverage, you do NOT need to submit an EC-1 form. Your coverage will automatically continue after March 1, 2011, until such time that you make a change.

Please note that if you mistakenly submit an EC-1 form during the open enrollment period, it will be assumed that you wish to switch from your VEBA-type plan to a plan available to all other State and County employees, and you will **never** be allowed to switch back into any of the VEBA-type plans specifically created by EUTF for HSTA VEBA members.

Q34: How much will I have to pay if I stay under the plan(s) that EUTF created specifically for HSTA VEBA members and how much will I have to pay if I switch to the EUTF plans for all other State and County employees?

A34: Please see Attachments 2 and 3 for the monthly employee contribution rates for those plans, effective March 1, 2011. Just as a reminder, the EUTF plans are unbundled.

Attachments:
1 – EC-1H Form
2 – Hawaii Employer-Union Health Benefits Trust Fund
For Active Employees Formerly Under the HSTA VEBA
BU 05, 45
Effective March 1, 2011
3 – Hawaii Employer-Union Health Benefits Trust Fund
Active Employees
All BU's Except BU 12
HSTA VEBA Active Employees Who Opt To Transfer To EUTF Plans (BU 05, 45)
BU 05, 45 Employees Hired On Or After January 1, 2011
Effective March 1, 2011

HSTA
EC-1H
DEC 2010

Hawaii Employer-Union Health Benefits Trust Fund

HSTA: Enrollment Form for Active BU 05 & 45 Employees

PLEASE SUBMIT THIS FORM EC-1H TO THE DOE EBU FOR ROUTING

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below.
Social Security numbers are required to process dependent enrollments.

Name (Last, First, Middle)

Work Phone (_____) _____
Home Phone (_____) _____
Mobile Phone (_____) _____

Residence Address (☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

Mailing Address (if different from above)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

(☐ Check this box if status change)

☐ Open Enrollment

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)
_____/_____/_____

☐ Mid- Year Qualifying Event (describe):
_____
Event Date: _____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)
_____/_____/_____

Domestic Partnership (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)(☐ Check this box if status change)
_____/_____/_____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:_____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.
If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Marriage, New Domestic Partnership, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used).
☐ Coverage & premium contrib. start 1st day of the first pay period following event
☐ Coverage & premium contrib. start 1st day of the **second** pay period following event

Completed by DOE → *Effective Date of Coverage:* _____ *Premium Contribution begins:* _____

SECTION 3: PLAN SELECTION

Medical Plan ☐ **Cancel/Waive Medical Coverage**

Choose only one box in each plan section

Type	Carrier Selection	Self	2-Party	Family
PPO	Fully Insured **HMSA** PPO **80/20** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
	Fully Insured **HMSA** PPO **90/10** Medical and Drug (HMSA), VSP, Chiroplan Hawaii	☐	☐	☐
HMO	Kaiser Medical and Drug, VSP, Chiroplan Hawaii	☐	☐	☐
Supplemental	Supplemental-HMSA Medical, Drug and Vision, Chiroplan Hawaii *	☐	☐	☐
	Supplemental-HDS Dental *	☐	☐	☐

Other Plans		Cancel/Waive	Self	2-Party	Family
Vision Service Plan (VSP)		☐	☐	☐	☐
Primary HDS Dental		☐	☐	☐	☐
Life	Standard Insurance Company	☐	☐		

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Do NOT Enroll ☐ Change Amount ☐ Cancel PCP

*To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal).

The EUTF created new health and life insurance benefit plans for HSTA VEBA members (BU05&BU45) in response to the December 7, 2010 oral ruling by Judge Sakamoto. The new plans offer HSTA VEBA members the same standard of coverage in benefits that they enjoyed under their HSTA VEBA plans. All HSTA VEBA members (BU05&BU45) will be transitioned to the newly created EUTF plans that offer the same standard of coverage in benefits on January 1, 2011.

SSN or EUTF ID#

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number or EUTF ID Number	*Relationship	Gender M/F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification– See Section 4.6 and 4.7 of "Instructions for Completing Form EC-1" for more information.

I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ **(initials)**

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ **(initials)**

Domestic Partner Certification – See Section 4.8 and 4.9 of "Instructions for Completing Form EC-1" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ **(initials)**

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

NOTE: The enrollment of HSTA VEBA members into these new health and other benefit plans is being done solely to comply with Judge Sakamoto's oral ruling and not to create any constitutional or contractual right to the benefits provided by these plans. Please note that the State does not agree with Judge Sakamoto's ruling and reserves the right to move HSTA VEBA members into regular EUTF plans if Judge Sakamoto's ruling is overturned or modified.

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit 05 / 45
Date EC-1H Received in Employing Office / /		DOE Phone Number	DOE Fax Number
DOE (or employer designee's) Printed Name DOE (or employer designee's) Signature:			Date of DOE (or employer designee's) Signature / /
Remarks:			

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA
BU 05, 45
EFFECTIVE MARCH 1, 2011

Benefit Plan	Type of Enrollment	*Monthly Employer Contribution	Monthly Employee Contribution	Total Contribution Required
MEDICAL PLANS				
HMSA - 90/10 **Medical, Drug, RSN Chiropractic, VSP Vision**	Self	$235.72	$180.16	$415.88
	Two-Party	$569.76	$434.52	$1,004.28
	Family	$727.42	$554.20	$1,281.62
HMSA - 80/20 **Medical, Drug, RSN Chiropractic, VSP Vision**	Self	$235.72	$74.80	$310.52
	Two-Party	$569.76	$178.82	$748.58
	Family	$727.42	$228.10	$955.52
Kaiser Comprehensive **Medical, Drug, RSN Chiropractic, VSP Vision**	Self	$235.72	$135.54	$371.26
	Two-Party	$569.76	$327.26	$897.02
	Family	$727.42	$417.72	$1,145.14
HMSA Supplemental **Supplemental Medical, Drug, Vision** **RSN Chiropractic**	Self	$139.66	$116.56	$256.22
	Two-Party	$336.70	$281.20	$617.90
	Family	$430.08	$358.80	$788.88
DENTAL PLAN				
HDS Dental	Self	$19.50	$12.80	$32.30
	Two-Party	$39.04	$25.58	$64.62
	Family	$80.76	$25.58	$106.34
HDS Supplemental Dental	Self	$0.00	$17.14	$17.14
	Two-Party	$0.00	$34.34	$34.34
	Family	$0.00	$51.46	$51.46
VISION PLAN				
VSP Vision	Self	$3.64	$2.40	$6.04
	Two-Party	$6.76	$4.42	$11.18
	Family	$8.84	$5.78	$14.62
LIFE INSURANCE				
Standard Life Insurance	Employee	$4.16	$0.00	$4.16

*Monthly Employer Contribution is subject to Legislative appropriation/approval

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
ALL BU'S EXCEPT BU 12
HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU 05,45)
BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011

EFFECTIVE MARCH 1, 2011

Benefit Plan	Type of Enrollment	*Monthly Employer Contribution	Monthly Employee Contribution	Total Contribution Required
MEDICAL PLANS				
EUTF PPO (HMA) - 90/10 Plan RSN Chiropractic	Self	$189.34	$124.80	$314.14
	Two-Party	$459.32	$303.22	$762.54
	Family	$586.10	$386.36	$972.46
EUTF PPO (HMSA) - 80/20 Plan RSN Chiropractic	Self	$189.34	$114.58	$303.92
	Two-Party	$459.32	$278.40	$737.72
	Family	$586.10	$354.70	$940.80
EUTF Prescription Drug (informedRx)	Self	$42.74	$28.08	$70.82
	Two-Party	$103.68	$68.28	$171.96
	Family	$132.48	$87.06	$219.54
EUTF HMO (HMSA) Prescription Drug RSN Chiropractic	Self	$232.08	$194.06	$426.14
	Two-Party	$563.00	$471.50	$1,034.50
	Family	$718.58	$600.96	$1,319.54
Kaiser Comprehensive Prescription Drug RSN Chiropractic	Self	$232.08	$149.14	$381.22
	Two-Party	$563.00	$361.72	$924.72
	Family	$718.58	$461.54	$1,180.12
Kaiser Basic Prescription Drug RSN Chiropractic	Self	$232.08	$90.46	$322.54
	Two-Party	$563.00	$219.20	$782.20
	Family	$718.58	$279.74	$998.32
EUTF Supplemental (HMSA) informedRx Prescription Drug RSN Chiropractic	Self	$136.02	$88.86	$224.88
	Two-Party	$329.94	$216.12	$546.06
	Family	$421.24	$275.22	$696.46
Royal State Supplemental Prescription Drug RSN Chiropractic	Self	$27.20	$16.30	$43.50
	Two-Party	$66.50	$40.48	$106.98
	Family	$75.92	$45.00	$120.92
EUTF High Deductible Health Plan (HMSA) Prescription Drug	Self	$232.08	$56.56	$288.64
	Two-Party	$563.00	$138.50	$701.50
	Family	$718.58	$176.72	$895.30
DENTAL PLAN				
HDS Dental	Self	$19.50	$12.80	$32.30
	Two-Party	$39.04	$25.58	$64.62
	Family	$80.76	$25.58	$106.34
VISION PLAN				
VSP Vision	Self	$3.64	$2.40	$6.04
	Two-Party	$6.76	$4.42	$11.18
	Family	$8.84	$5.78	$14.62
LIFE INSURANCE				
Standard Life Insurance	Employee	$4.16	$0.00	$4.16

*Monthly Employer Contribution is subject to Legislative appropriation/approval

12/29/10